STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING _____ B. WING _____	R-C 04/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00124238 completed on 2/27/2013. This visit was in conjunction with the Investigation of Complaints IN00126199, IN00126219, and IN00126028. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 24, 2013. Complaint IN00124238 - Corrected. Survey dates: March 26, 27, 28, and April 1 and 2, 2013 Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630 Survey Team: Dinah Jones, RN - TC Marcy Smith, RN Leia Alley, RN Patti Allen, RN Census bed type: SNF/NF: 47 Total: 47 Census payor type: Medicare: 4 Medicaid: 37 Other: 6 Total: 47	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING _____ B. WING _____	R-C 04/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	**2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Sample: 3 Friendship Healthcare was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00124238. Quality Review completed on April 12, 2013; by Kimberly Perigo, RN.	{F 000}		